PATIENT AUTHORIZATION FOR USE / DISCLOSURE OF MEDICAL INFORMATION

Patient Name: ______________________ **Date of Birth:** ______________

Other name(s) used: ______________________________________

Mailing Address: ______________________________________

Phone Number: ______________________ MRN: ______________

I authorize: ____________________ **to disclose to:** ____________________

Address: ______________________________________

City, State, Zip Code: ______________________________________

Contact Person: ______________ Phone: ______________ Fax: ______________

If there is a **due date or deadline** please specify that date here: ______________

Method of disclosure: ☐ Mail ☐ Pick up onsite ☐ Portal ☐ Fax ☐ Email: ______________

Purpose of the disclosure: ☐ Continuity of Care / send to my other healthcare provider ☐ Insurance ☐ Personal ☐ Legal ☐ Work/School ☐ Disability Determination ☐ Other ______________

Dates of Treatment: ☐ All ☐ Most recent **Or** From: ______________ (MM/DD/YYYY) To: ______________ (MM/DD/YYYY)

Specific information to be disclosed: Indicate the type(s) of materials to be released.

- ☐ History & Physical
- ☐ Progress Notes/Follow-up Notes
- ☐ Operative/Procedure notes
- ☐ Images on disc (PET, CT, US)
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Billing records
- ☐ Hospital records (explain below)
- ☐ Consultation Reports
- ☐ Records from other facilities (explain below)
- ☐ All records/entire chart
- ☐ Other/Explain: ______________________________________

Specific authorization for sensitive information

Do	Do not release		Initials	Do	Do not release		Initials
☐	☐	Mental health information	______	☐	☐	Genetic information	______
☐	☐	Drug, Alcohol, or substance abuse	______	☐	☐	HIV/AIDS test results/treatment	______

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Austin Cancer Centers in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization might be re-released by the person or organization that receives it and it may then no longer be protected by Federal or Texas privacy regulations.

This authorization expires in one year or on this specific date or event: ______________. I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this authorization, if requested. A photocopy of this authorization is as valid as the original.

______________________________ ______________________________

Signature of Patient (or Patient Representative) Date

______________________________ ______________________________

Printed Name of Patient (or Patient Representative) Authority of Representative to act for Patient

If this form is signed by a person other than the patient, supporting documentation must be submitted along with this form. Examples include Medical Power of Attorney or documentation of legal guardianship.